MDR Tracking Number: M5-05-1610-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution – General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 1-31-05.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the non-electric pad-moist, therapeutic exercises, ultrasound, massage therapy, electrical stimulation and office visits for 3-18-04 through 5-28-04 were not medically necessary.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees involved in the medical dispute to be resolved.

On 3-7-05 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The carrier denied CPT Code 99070 on 3-18-04 with a "G – Unbundling." Per rule 133.304(c) and 134.202(a)(4) carrier didn't specify which service this was global to. **Recommend reimbursement per Rule 134.202(c)(1) of $16.75.**

No denial code was listed by the carrier for CPT code 99212 on 3-19-04. Pursuant to Rule 133.304(c) "The explanation of benefits shall include the correct payments exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s)." The carrier's EOB denials are unclear. Therefore, these services will be reviewed in accordance with the Medicare Fee Schedule. There is an unverified indication that this service was paid by the carrier. **Reimbursement is recommended in the amount of $46.41.**

No denial code was listed by the carrier for CPT code 99212 on 3-26-04. Pursuant to Rule 133.304(c) "The explanation of benefits shall include the correct payments exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s)." The carrier's EOB denials are unclear. Therefore, these services will be reviewed in accordance with the Medicare Fee Schedule. There is an unverified indication that this service was paid by the carrier. **Reimbursement is recommended in the amount of $46.41.**

No denial code was listed by the carrier for CPT code 99080-73 on 3-26-04. Pursuant to Rule 133.304(c) "The explanation of benefits shall include the correct payments exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s)." The carrier's EOB denials are unclear. Therefore, these services will be reviewed in accordance with the Medicare Fee Schedule. There is an unverified indication that this service was paid by the carrier. **Reimbursement is recommended in the amount of $15.00.**

Regarding CPT code 97140 on 5-21-04 and CPT codes 99212, 97110 and 97112 on 5-24-04: Neither the carrier nor the requestor provided EOB's. There is no "convincing evidence of the carrier's receipt of the request for reconsideration" according to 133.307 (g)(3)(A). **No reimbursement recommended.**

The carrier denied CPT Code 99080-73 on 5-26-04 with a U for unnecessary medical treatment, however, the TWCC-73 is a required report and is not subject to an IRO review per Rule 129.5. This dispute will be forwarded to Compliance and Practices for this violation of the Rule. The Medical Review Division has jurisdiction in this matter and, therefore, recommends reimbursement. Requestor submitted relevant information to support delivery of service. **Recommend reimbursement of $15.00.**

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees totaling $139.57 from 3-18-04 through 5-26-04 outlined above as follows:

- In accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c);
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Decision and Order is hereby issued this 10th day of May 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

NOTICE OF INDEPENDENT REVIEW DECISION

April 15, 2005

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-05-1610-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 38 year-old male injured his left shoulder and neck on ___ when the bus he was driving was struck by an ambulance. He has been treated with therapy, medications and a Transcutaneous Electrical Neural Stimulation (TENS) unit.

Requested Service(s)

Non-electric heat pad-moist, therapeutic exercises, ultrasound, massage therapy, electric stimulation, office visit for dates of service 03/18/04 through 05/28/04

Decision

It is determined that there is no medical necessity for the non-electric heat pad-moist, therapeutic exercises, ultrasound, massage therapy, electric stimulation, office visit for dates of service 03/18/04 through 05/28/04 to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation indicates this patient received two units of electrical stimulation, ultrasound and massage therapy on the dates of service in question. Only one unit of each of these services is medically necessary to treat this patient's medical condition. A second unit of electrical stimulation, ultrasound, and massage therapy is a duplication of service and therefore not medically necessary to treat this patient's medical condition. There is also no medical documentation to support the use of more than two units of therapeutic exercise on each patient encounter. Therefore, the electrical stimulation, ultrasound, massage therapy and therapeutic exercise are not medically necessary to treat this patient's medical condition.

Medical record documentation also does not indicate the medical necessity of the office visits in question. Performing this level of evaluation and management on each and every patient encounter is not medically necessary, especially during an established treatment plan. Additionally, there is no medical documentation to support the use of non-electric moist heat pad. It is not documented in the medical records as performed and therefore is not medically necessary.

In summary, the non-electric heat pad, moist, therapeutic exercises, ultrasound, massage therapy, electric stimulation, and office visits for dates of service 03/18/04 through 05/28/04 are not medically necessary to treat this patient's medical condition.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm

Attachment

Attachment

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M5-05-1610-01

Information Submitted by Requestor:

- Position Statement
- Diagnostic Tests
- Functional capacity evaluation
- Consents
- Designed Doctor Evaulation
- Progress Notes

Information Submitted by Respondent:

- Carrier's Position